Developmental Trauma Disorder 2025
Update on Innovations in Conceptualization and Interventions

Developmental Trauma Theories (Adapted from Ford, J. D., & Greene, C. A. (2025). Psychological and biological theories of child and adolescent traumatic stress disorders (Chapter 5). In M. Landolt, M. Cloitre, U. Schnyder (Eds.), *Evidence-based treatments for trauma-related disorders in children and adolescents 2nd Edition*. New York: Springer International)

The impact of exposure to traumatic stressors is inextricably interwoven with—and potentially highly disruptive to—the inherently immature child's biological and psychosocial development (see also chapter 19 for the preschool age). Children exposed to traumatic stressors may experience profound alterations in the development of their bodies, minds, and relationships which can lead not only to PTSD or related symptoms but also to lifelong gaps, deficits, or limitations in their mental and physical health. The adverse impact of exposure to traumatic stressors on childhood development has been well documented in several key biopsychosocial domains including:

a. Emotion dysregulation: thiscore developmental impairment associated with childhood exposure to traumatic stressors (D'Andrea et al. 2012) involves monitoring and maintaining the integrity of the body and self either automatically or self-reflectively (i.e., cognitively)
b. Impaired executive functions (i.e., attention, learning, problem solving, and working (short-term), declarative (verbal), and narrative (autobiographical) memory),
c. Altered personality formation and integration, self-concept, and self-worth
d. Altered relationships (attachment working models, bonding, communication, and security)

Emotion regulation begins in infancy, initially with relatively automatic reactions to distress (crying) and pleasure (visual attention, smiling) (Perry et al. 2016). If the infant has repeated success in coping with mild brief episodes of fear, self-regulation is enhanced. The calming presence of a caregiver who helps the infant to titrate the extent of exposure to frightening stimuli and contexts is a crucial source of attachment security that enables the infant to learn self-regulation by experiencing co-regulation (Evans and Porter 2009). Traumatic stressors, especially when they disrupt or compromise the secure infant-caregiver attachment bond, can result in lasting impairments when they prevent the infant from achieving the crucial developmental milestone of learning how to regulate their body when experiencing fear or associated distress (Moutsiana et al. 2014).

In the second and third years of life, continued rapid growth in the brain infrastructure enables the child to develop awareness of self and others as separate individuals with distinct goals, expectations, and emotions. When traumatic events occur, especially if they compromise caregiving, the toddler's neural and neurochemical circuits are likely to become organized by stress reactivity, leading to persistent states of extreme emotional distress (e.g., shame, absence of empathy, anger expressed in aggressive behavior) and impairment in the ability to express or modulate these internalized or externalized emotion states and to inhibit impulses, think clearly, set and achieve goals, trust. and cooperate in relationships (Dackis et al. 2015; Kim-Spoon et al. 2013).

In middle childhood and preadolescence, trauma-related impairments can cause or exacerbate a wide range of internalizing (e.g., depression, agoraphobia, panic, obsessive-compulsive, social anxiety, phobias, dissociative disorders), externalizing (e.g., oppositional defiant or conduct disorder, attentional or impulse control disorders, mania/bipolar disorder), and psychosomatic (e.g., eating disorders, sexual, and sleep disorders) problems. These problems in turn compromise successful development and performance in school and activities and with peers and family. Impaired emotion regulation in adolescence can become even more complex, including substance use or personality disorders and serious problems in the legal, school, family, and community domains (e.g., incarceration, truancy, teen pregnancy, gang involvement, suicidality). Traumatic stress disorders thus can not only cause severe immediate symptoms but moreover can alter a child's entire life course by undermining the development of foundational capacities such as emotion regulation (Nusslock and Miller 2016).

The definition of developmental trauma has been expanded in several ways in order to include events, experiences, and contexts involving threat or deprivation that adversely affect child development (McLaughlin et al., 2020). An expanded framework for the definition and assessment of adverse childhood experiences (ACEs) has been developed based on research showing that neighborhood (Schroeder et al., 2022) and community (Warner, Leban, Pester, & Walker, 2023) adversities account for additional risk of biopsychosocial and developmental impairments over and above the effects of the original ACEs domains of maltreatment (i.e., abuse, neglect) and household dysfunction (i.e., impaired, violent, or incarcerated family members and divorce) (Folk et al., 2022). Living in poverty (De France, Evans, Brody, & Doan, 2022), in unsafe (Choi et al., 2019) or impoverished (Douglas, Alvis, Rooney, Busby, & Kaplow, 2021) neighborhoods, exposure to community violence (Nothling, Suliman, Martin, Simmons, & Seedat, 2019; Santacrose, Kia-Keating, & Lucio, 2021) or sibling or peer violence (Sharpe, Fink, Duffy, & Patalay, 2022) and bullying (Idsoe et al., 2020), and involvement in commercial sexual exploitation/sex trafficking (Greenbaum, 2021) are associated with severe internalizing and externalizing problems, self-harm and suicidality, educational and learning problems, and traumatic stress disorders.

Moreover, societal adversities that lead to discrimination, stigma, disparities, and violence and hate crimes are traumatic and profoundly developmentally disruptive for children and adolescents, including due to racism (Allwood, Ford, & Levendosky, 2021; Allwood et al., 2022; Auguste, Cruise, & Jimenez, 2021; Charak et al., 2023; MacIntyre, Zare, & Williams, 2023; Rides At The Door & Shaw, 2023; Roach, Haft, Huang, & Zhou, 2023), homophobia and transphobia (Schnarrs et al., 2022), and xenophobia (Beier, 2020; Cai & Lee, 2022; Cerdena, Rivera, & Spak, 2021; Tineo, Bonumwezi, & Lowe, 2021).

Developmental Trauma Disorder 2025
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Developmental Trauma, Developmental Trauma Disorder, and Complex PTSD

(Adapted from Ford, J. D. (2023). Complex PTSD and emotion dysregulation: The role of dissociation (pp. 481-493). In M. Dorahy, S. Gold, & J. O'Neil (Eds.), *Dissociation and the dissociative disorders: Past, present, and future*. New York: Routledge. Doi: 10.4324/9781003057314-36)

Both the DESNOS and ICD-11 formulations of complex PTSD (cPTSD) highlight how emotion dysregulation is a fundamental consequence of children's exposure to developmental trauma, but neither includes the full range of developmental trauma's sequelae. An alternative formulation of complex PTSD for children, Developmental Trauma Disorder (DTD) provides a more complete picture (Ford et al., 2013; Ford, Spinazzola, van der Kolk, & Grasso, 2018; Ford, van der Kolk, & Spinazzola, 2021; Spinazzola, van der Kolk, & Ford, 2018, 2021; B. van der Kolk, Ford, & Spinazzola, 2019; B. A. van der Kolk, 2005). DTD involves 15 symptoms in three domains of dysregulation: emotional/somatic, cognitive/behavioral, and self/ relational.

Developmental Trauma Disorder (DTD) Criteria

- **Criterion A: lifetime exposure to two types of stressors**
  - A1: interpersonal victimization: experienced or witnessed physical or sexual assault or abuse, or witnessed family or community violence;
  - A2: disruption in attachment bonding to primary caregiver(s): loss of, prolonged separation from, or neglect by a primary caregiver.
- **Criterion B (current emotion or somatic dysregulation, 4 items; 1 required for DTD)**
  - B1: Emotion dysregulation (either B1.a. extreme emotional distress; or B1.b. impaired recovery from emotional distress)
  - B2: Somatic dysregulation (either B2.a. aversion to touch; or B2.b. aversion to sounds; or B2.c. bodily dysfunction/illness that cannot be medically explained/resolved)
  - B3: Impaired access to emotion or bodily feelings (either B3.a. inability to experience emotion; or B3.b. anaesthesia or paralysis that cannot be medically explained/resolved)
  - B4: Impaired expression of emotion or body states (either B4.a. alexithymia; or B4.b. inability to express bodily feelings/states in words)
- **Criterion C (current attentional or behavioral dysregulation, 5 items; 2 required for DTD)**
  - C1: Attention bias toward or away from threat (either C1.a. preoccupation with real/perceived threats; or C1.b. impaired ability to recognize actual or potential danger)
  - C 2: Impaired self-protection (either C2.a. extreme risk-taking or reckless or careless behavior; or, C2.b. intentional seeking of conflict or violence)
  - C 3: Maladaptive self-soothing (attempts to reduce emotional distress that are primitive and obsessional)
  - C4: Non-suicidal self-injury (self-harm intended to reduce/contain distress)
  - C5: Impaired ability to initiate or sustain goal-directed behavior (consistent problems in independently starting and completing actions designed to achieve personal goals)
- **Criterion D (current relational- or self-dysregulation, 5 items; 2 required for DTD)**
  - D1: Self-loathing (viewing self as irreparably damaged or defective)
  - D 2: Attachment insecurity and disorganization (either D2.a. parentified attempts to protect caregivers; or D2.b. difficulty engaging emotionally with primary caregiver(s) following separation)
  - D 3: Betrayal-based beliefs about relationships (either D3.a. expectation of betrayal in relationships; or D3.b. oppositional-defiance based on expecting to be coerced or exploited in relationships)

- D4: Reactive verbal or physical aggression (including proactive aggression intended to prevent/respond to harm/injury)
- D5: Impaired psychological boundaries (either D.5a. promiscuous enmeshment—seeking physical or emotional intimacy from any available source; or D5.b. consistently needing emotional reassurance in relationships)
- D6: Impaired interpersonal empathy (either D6.a. intolerant of others' distress; or D6.b. excessive responsiveness to others' emotional distress)

DTD includes several sequelae of exposure to victimization and attachment disruption that are not defined as symptoms in the ICD-11's cPTSD features of disturbances of self-organization (DSO). Although DSO includes emotion dysregulation symptoms of inability to recover from intense distress and emotional numbing (Haselgruber, Solva, & Lueger-Schuster, 2020), it does not reference somatic expressions of emotion dysregulation. DTD's somatic dysregulation symptoms (B2, B3b, B4b) identify somatic forms of emotion dysregulation, consistent with the importance of somatic expressions of distress in child and adolescent PTSD (Zhang, Zhu, Du, & Zhang, 2015) and somatoform dissociation (Silberg, 2021). In the self-dysregulation domain, DTD focuses on sense of self as damaged, as opposed to the emphasis on self as worthless or a failure in cPTSD. DTD also includes symptoms of maladaptive self-soothing and non-suicidal self-injury, although these were found to be indicators of behavioral dysregulation rather than a disturbance of self-perception *per se* (Ford et al., 2018).

The DTD domain of attentional and behavioral dysregulation also includes several other symptoms that may be reflective of dissociation but are not specified in the ICD-11 formulation of cPTSD: preoccupation with or disregard for potential threats, reckless or risky behavior, and impairment in goal-directed behavior. In the relational dysregulation domain, DTD symptoms extend beyond the cPTSD relationship symptoms, which focus on relational avoidance and detachment. DTD does address *over*-regulation in relationships with symptoms representing restricted capacity for empathy and the avoidant component of disorganized attachment, but it also includes manifestations of severe emotional *under*-regulation in relationships, in the form of the insecurity component of attachment disorganization, as well as symptoms of self-other boundary confusion, empathic enmeshment, and reactive aggression.

Although DTD was initially formulated to identify symptoms consistent with childhood and adolescent developmental epochs, its proposed antecedents (i.e., traumatic victimization and disrupted attachment bonding with primary caregivers) are consistent with those proposed for the adult versions of complex PTSD, DESNOS (B. A. van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005) and cPTSD (Cloitre et al., 2020) (i.e., severe and chronic interpersonal violence or victimization). The addition of attachment disruption as an antecedent for DTD aligns it with evidence cited above that disorganized attachment is a sequela of traumatic disruption of primary attachment bonding and both predictive of, and an ongoing contributor to, emotion dysregulation and pathological dissociation throughout childhood and into adulthood. By explicitly including attachment disruption as well as traumatic interpersonal victimization, DTD thus more closely aligns its stressor criterion with the antecedents of pathological

dissociation and emotion dysregulation, compared to the sole focus on trauma as the stressor criterion for both DESNOS and cPTSD.

In terms of symptoms, DTD's core domain, emotion dysregulation, mirrors the central feature of both DESNOS and cPTSD. However, rather than placing dissociative symptoms as a separate domain (as in DESNOS) or excluding them entirely (as in cPTSD), DTD incorporates both psychoform (B3, B4) and somatoform (B2, B3, B4) dissociation into the domain of emotion dysregulation symptoms (see Table 1). Negative dissociation symptoms (e.g., depersonalization, derealization, fugue) and positive dissociation symptoms (e.g., flashbacks, part-selves) are not explicitly referenced in DTD due to the difficulty of distinguishing these phenomena from children's normative experiences and reactions to stressors (Silberg, 2021). However, with the exception of a symptom explicitly referencing DID-like part-selves, the psychoform dissociation symptoms could be assessed with DTD's emotion dysregulation symptoms (i.e., under-regulation characteristic of the EP and over-regulation characteristic of the ANP). If adapted for adults, DTD could explicitly include depersonalization, derealization, and fugue states within the rubric of its emotion dysregulation symptoms. DTD's somatic dysregulation symptoms (i.e., unawareness of or aversion to bodily sensations, and medically unexplained physical illness, pain, or disability) directly address the somatoform domain of pathological dissociation.

Thus, DTD accounts for both psychoform and somatoform dissociation without adding dissociation as a separate symptom domain. DTD also provides opportunities for identifying dissociation as a contributor to attentional (i.e., unawareness of threats), behavioral (e.g., maladaptive self-soothing, self-harm, impaired goal-directed behavior), and relational (e.g., impaired empathy and boundaries, aggression, disorganized attachment) symptoms—similar to, but extending beyond the potentially dissociation-related symptoms that are included in DESNOS (e.g., maladaptive self-soothing, self-harm, severe anger).

Unlike cPTSD, DTD thus includes a wide range of symptoms of dysregulation that potentially reflect the action of dissociation, with a fuller representation of disorganized attachment than in DESNOS. The parsimony of symptom domains in cPTSD is evident in DTD, with psychoform and somatoform dissociative symptoms incorporated in a single domain of emotion and somatic dysregulation, rather than as separate domains as DESNOS does for dissociation and somatization. DTD therefore could potentially increase both the diagnostic sensitivity and informativeness of the original DESNOS formulation of complex PTSD compared to ICD-11's cPTSD as a result of including dissociation (as is done currently on an implicit basis with psychoform dissociation and explicitly with somatoform dissociation), while potentially improving diagnostic specificity and efficiency compared to DESNOS by not requiring psychoform and somatoform dissociation to serve as separate criteria.

Trauma Memory Processing in Psychotherapy for PTSD and DTD

(Adapted from: Ford, J. D. (2018). Trauma memory processing in PTSD psychotherapy: A unifying framework. *Journal of Traumatic Stress 31*, 933-942. https://doi.org/10.1002/jts.22344)

Two questions will be addressed in this discussion of psychotherapy for PTSD and DTD. What exactly is the "trauma memory" that is being processed in psychotherapy for PTSD and DTD, and what actually is involved in the "processing" of those memories?

The hallmark of PTSD and DTD is hypervigilance – a sense of needing to be on guard for danger – which is triggered by intrusive trauma memories (that often are subconscious rather than conscious). The best way to reduce hypervigilance is not to try to convince a trauma survivor that they are safe, but instead to help the survivor to *recognize and recall trauma memories on purpose*. When trauma survivors try to avoid trauma memories, this pushes the memories into the back of their mind where they never go away and are always on the verge of being activated by any reminder of the trauma. When trauma memories are avoided in this manner, they become the "danger" that the survivor fears may happen at any moment – so the very act of avoidance fuels the hypervigilance, and when some day-to-day reminder reactivates the sub-conscious trauma memory this creates a vicious cycle by escalating the sense of being unsafe and increasing the survivor's hypervigilance.

By contrast, when trauma memories are recalled with therapeutic assistance, this can not only break the vicious cycle of avoidance and hypervigilance, but also provides an opportunity to help the trauma survivor to expand their often very narrow, laser-like memory of what happened in traumatic events. Enlarging the memory does not mean falsely re-working the traumatic aspects to make the memory superficially more "positive." Trauma memories can be enlarged by helping the survivor to more carefully examine their own thoughts, feelings, and actions in hindsight than is possible for anyone to do in the moment of a traumatic experience. Trauma survivors often find that there is evidence that they reacted with courage, strength, and perseverance, which did not prevent the experience from being harmful but which enabled them to survive – and even more importantly, which enabled them to be true to their core values in ways that they were unaware of at the time. Making the shift from avoidance of trauma memories and being trapped in a cycle of continuing hypervigilance and unwanted intrusions of those memories (intrusive re-experiencing) to self-directed intentional retrieval, elaboration and self-referential reappraisal of trauma memories, thus can enable trauma survivors to make those memories more tolerable – although never eliminating their pain and suffering– and to also escape the trap of feeling that they must hide from not only the memories but also a sense of being permanently damaged and shamed (Herman, 1992). So the answer to the first question is that it is **the entirety of a trauma memory**, including aspects that reflect the survivor's resilience and core self, that must be processed in psychotherapy.

Trauma memory processing (TMP) in PTSD/DTD psychotherapy involves: (1) recall of a specific traumatic event in detail, (2) identification and expression of prominent beliefs and

emotions, both in the event and currently, (3) identification and reflection on the relational context before, during, and after the traumatic event; and (4) awareness of the present context and safety.

First, a single traumatic event (or closely related series of events) is selected, in order to facilitate the intentional retrieval of a specific memory. The therapist guides the individual in accessing their memory of that index event by re-telling (orally or in writing) or imaginally recalling the event. This is done in order to facilitate recall of and reflection on the personally significant elements and/or meaning that comprise the traumatic event, rather than avoiding the retrieval or appraisal of the event—in contrast to the typically fragmented, jumbled, and disconnected quality of intrusively re-experienced memories.

Further, the individual is invited to include in the re-telling or recollection of the trauma memory any of the other people involved, directly or indirectly, in the event(s), and what they said and did (or failed to do). In order to enhance awareness of the traumatic event's relational context, attention may be directed toward the bodily feelings, emotions, thoughts, and behavioral reactions that the person recalls having in relation to other people in the event, and the reactions of other people in (or related to) the event(s) that are perceived as relevant. Toxic relational contexts that often surround and occur immediately during traumatic events can amplify PTSD (particularly dissociative) symptoms (Frewen, Brown, DePierro, D'Andrea, & Schore, 2015). Even when the relational context is relatively benign, restoring or strengthening awareness of the relational context involved in traumatic events has been hypothesized to facilitate a shift from the fragmented perceptual memory mode (i.e., threat processing) characterizing flashbacks to more adaptive episodic (i.e., goal oriented, self-referential) modes of processing (Brewin, 2014).

Additionally, the therapist actively assists the individual in retaining awareness of their present circumstances, including providing for physical and emotional safety in the therapeutic setting and relationship. These tactics can be understood as activating both goal-oriented and self-referential processing with a focus on enhancing the client's ability to engage in present-centered mindfulness and to be aware of the safety and support provided by the therapeutic relationship.

Finally, TMP therapies help the survivor to reappraise the beliefs engendered by traumatic experiences in order to incorporate positive beliefs about self, others, relationships, the world, and the future that acknowledge, but are not based solely or primarily on, past traumas. Cognitive reappraisal may occur, but is not formally taught, in both PE and EMDR. The emergence of meaning making through reappraisal involves self-referential processing, and as a result a reduction in the emotional distress and sense of helplessness, vulnerability aloneness, blame, and psychic damage that are recognized in the *DSM-5* as a feature of PTSD. Reappraisal and meaning making thus represent a fundamental shift from the passive immersion in the re-experiencing of traumatic memories to the active intentional retrieval of and self-referential reflection on the meaning of those memories that the survivor chooses to carry forward in their life. In this way, TMP restores a sense

of control to the trauma survivor – not control over the traumatic experiences, but control over memories of them and what those experiences mean when the survivor is able to recognize that, despite being emotionally and morally injured, their core self, personal strengths, and a meaningful potential future are intact. This is what Harvey (1996) described as "mastery of memory."

Unique Features of the Varied Approaches to TMP in PTSD Psychotherapy

A variety of specific procedures are utilized by different therapeutic models for TMP. These include variations in three domains: (1) how trauma memories are accessed, (2) how the intensity of distress is titrated, (3) how focal beliefs and emotions are identified and reappraised.

Accessing Trauma Memories. The imaginal exposure component of PE involves a first-person present-tense sequential walk-through of a specific trauma memory, followed by a collaborative discussion to identify changes in distress, specific emotions, and beliefs associated with the memory re-telling. By contrast, in CPT, STAIR-NS and TF-CBT, the memory is re-told in writing or creatively assembled (e.g., with drawings or collage) as a story-like narrative, BEPP and NET use a blended combination of the first-person present tense walk-through and creative narrative procedures. NET and STAIR-NS also assist patients in constructing a larger narrative of their entire life story as a context for memories of specific traumatic events. In a modified version of CPT (CPT-C), as well as CT and EFTT, trauma memories are discussed but not repeatedly re-told or formally reconstructed as a narrative. In EMDR, exposure is done in 30- second intervals in which bilateral stimulation (e.g., saccadic eye movements) are paired with silent focusing on three aspects of the trauma memory and the person's current state of mind and body: a single image representing the traumatic event, an associated negative belief, and any disturbing bodily sensations—followed periodically by discussions of any changes the patient notes in emotions, thoughts, or sensations. Finally, PE includes an *in vivo* exposure component that involves intentionally placing oneself in proximity to current day reminders of past traumatic events. Other trauma-focused therapies involve either symbolic or *in vivo* trauma memory processing without requiring the survivor to recall the memory in detail: Emotionally Focused Therapy for Trauma (EFTT) uses psychodramatic gestalt therapy techniques (e.g., the empty chair) to symbolically process trauma memories; Trauma Affect Regulation: Guide for Education and Therapy (TARGET) teaches a step-by-step sequence to shift from symptomatic reactions to meaning-making appraisals of recent experiences that elicit intrusive trauma memories, thus using naturalistic *in vivo* experiences as a way to access and process memories of traumatic events in the context of the survivor's current and overall life narrative. The common element in these varied approaches is guiding the survivor in gaining a sense of efficacy and current safety by reflecting on rather than reacting to and and avoiding trauma memories.

Titration of Distress. Some approaches to TMP use a desensitization protocol to systematically titrate the intensity of distress anticipated and felt while accessing trauma memories, beginning with stressful events that may or may not be traumatic but that are not the most currently troubling past events, and then working forward in an informal or formal hierarchy to progressively

more distressing memories (i.e., EFTT, EMDR) or *in vivo* reminders (i.e., PE). Other TMP models identify events for intensive memory processing as they emerge during a formal life narrative (i.e., NET, STAIR-NS, TARGET) or based on the individual's selection of the traumatic event(s) that have had or are currently having the greatest negative impact on their life (i.e., BEPP, CT, TF-CBT, EFTT). PE allows some latitude in selecting a traumatic event for therapeutic exposure, but encourages beginning with the most currently distressing event so as to maximize emotional engagement in TMP. A third variation, found in CT, CPT-C (the version of CPT that does not include a trauma narrative) and EFTT, has the individual focus on beliefs or relationship problems that are associated with traumatic events, rather than on the details of the events *per se.*

Different approaches are taken in the TMP therapies to strengthening and sustaining the person's awareness of, and confidence in, both internal and interpersonal resources. In CPT, patients write and share with their therapist (and group members, in group therapy) an "impact statement" describing how they and their life have been affected by the traumatic event(s). In NET, the patient's life/trauma narrative is inscribed as a formal documented testimonial at the conclusion of therapy in order to signify the courage and integrity of the patient's truth-telling. Similarly, in BEPP, a farewell ritual commemorates the patient's courage in facing the trauma. In EMDR, personal strengths and relational resources are identified in advance and purposefully "given" to the patient by the therapist, and by the patient her/himself, as a validation and source of security, hope, and efficacy, periodically during the re-living of a traumatic event. EFTT emphasizes facilitating recognition that emotions which had seemed to be overwhelming do not need to be avoided and can become manageable. In TARGET, a sequence of emotion regulation skills is taught that enable the survivor to shift from trauma-related "alarm" reactions to self-directed focusing guided by core values and strengths.

Identification and Reappraisal of Focal Beliefs and Emotions. Some TMP therapies help the individual to make an explicit link between key moments in a traumatic memory and their core beliefs and emotions. In PE the therapist guides the individual in identifying "hot spots" (i.e., moments of peak emotional intensity) based on self-monitoring of subjective units of distress (SUDS) experienced during the walk-through of the traumatic event, followed by a pause (referred to as a freeze frame) in which the therapist probes in order to help the individual access a more detailed recollection of specific bodily reactions, emotions, thoughts, and SUDS before proceeding with the walk-through. Similarly, CT conducts an "updating" of trauma memories that begins with identifying the worst moments within a traumatic event and the person's associated core beliefs. The update differs from PE's "hot spot" procedure in that the therapist also assists the individual in incorporating new information from their re-examination of the traumatic event and from a reappraisal of the validity of the trauma-related beliefs. Then the updated (reappraised) beliefs are used as new context in order to enable the individual to access memories of the worst moments in the traumatic event with confidence, self-affirmation, and conscious awareness that those moments are no longer occurring except as memories.

Other therapeutic approaches to TMP provide guidance in the reappraisal of trauma memories without specifically linking this to hot spots or worst moments in the traumatic event. EMDR guides the person in focusing on an image, thought, and body sensations related to the traumatic event that she or he views as encapsulating the personal meaning of the experience. In EFTT, the therapist utilizes either "empathic exploration" (i.e., encouraging awareness and non-judgmental acceptance of distressing emotions and beliefs) or "imaginal confrontation" (i.e., "empty chair" or "two-chair dialogue" imaginal interactions with trauma perpetrators) in order to enable the person to recognize and express emotions or thoughts related to relational problems that were unexpressed in the traumatic event or that are related to the trauma and are unresolved. BEPP has patients bring memorabilia related to the traumatic event into TMP sessions in order to stimulate emotional associations, and (similar to EFTT) emphasizes identifying a range of emotions both when recalling "hot spots" in the traumatic event, as well as when writing an ongoing letter documenting the emotional impact that the trauma has had on their life (similar to the "impact statement" utilized in CPT). NET, CPT, STAIR-NT, and TF-CBT assist the person in describing prominent thoughts and emotions while developing a trauma memory narrative, as does TARGET while the survivor develops narratives of current and past experiences that are associated with past traumas, and also in identifying beliefs that they hold about self and others that reflect their positive life experiences and provide a counterbalance and context for a hopeful future in their life story.

Summary: Three Prototypes of TMP. *In vivo* processing represents a first type of TMP in which the goal is enhanced self-directed conscious awareness and self-referential reappraisal of trauma memories as they occur in daily life in the form of not only intrusive re-experiencing but also avoidance, hyperarousal, altered affect/cognitions, or dissociative symptoms.

Intensive re-telling or re-imagining of trauma memories represents a second type of TMP in which threat processing is intentionally activated by intensive imaginal memory retrieval, with support for self-directed goal-oriented reappraisal of the event and self-referential reflection on associated beliefs and emotions.

A third type of TMP involves self-directed goal-oriented retrieval, and self-referential cognitive reappraisal, of trauma-related beliefs and emotions, without intensive memory re-telling. Type 3 cognitive reappraisal TMP can be done either by purposeful reflective remembering imaginally, or by accessing trauma-related beliefs/emotions as they occur *in situ*. This approach is exemplified by the trauma-focused present-centered approach of TARGET, as well as the lifeline that is developed in TARGET, NET, and BEPP.

The PRISM Framework for the Treatment of Developmental Trauma Disorder

(Adapted from Courtois, C. A. & Ford, J. D. (2024). Trauma Transformative Principles in the Treatment of Complex Traumatic Stress Disorders (Chapter 9, pp 235-263). In J. Tucci, J Mitchell, S. Porges & E. Tronick (Eds.*), Handbook of Trauma-Transformative Practice: Emerging Therapeutic Frameworks for Working with Individuals, Families and Communities Impacted by Abuse and Violence*. London: Jessica Kingsley Publishers)

The acronym *PRISM* refers to psychotherapy for trauma survivors that is **P**ersonalized, **R**elational, **I**ntegrative, **S**equenced/**S**trategic, and **M**ulti-**M**odal/**M**ulti-Dimensional -- designed to be highly responsive to traumatized individuals, enabling them to achieve not only recovery and resilience but also a fundamental transformation from living in survival mode to restoring healthy development.

Personalized Treatment

P*ersonalization of the treatment* and are necessitated to counter the objectification that individuals with histories of complex trauma have experienced and endured. The therapist seeks to directly counter this non-recognition and invalidation, whether by it occurred by commission or omission (or both) by exhibiting a deep interest in and resonance with the client. These, along with other factors such as personal reliability and consistency, ongoing emotional regulation, and boundary management, serve to create a secure treatment relationship. It is advisable for therapists to generally determine the client's attachment style as it will assist them in adjusting their own interventions. Since these clients tend to be emotionally dysregulated and skittish regarding relationships (covering the spectrum from overly attached/compliant to overly detached/defiant and anything in between, often exhibited in an unexpected and paradoxical way), the therapist must tailor their responses to notice with the client and to build trust incrementally. They must also expect relapses and ruptures which they seek to identify and resolve in the interest of relational trust and growth.

P*sycho****p****hysiological approaches* are incorporated into the treatment as posttraumatic responses are physiological as well as psychological. As noted by Van der Kolk (2014), "the body keeps the score" and attention to the client's physical responses is used as a means of accessing and identifying emotions counters dissociation/fragmentation. Many clinicians have found that close attention to the hyper-activation and hypo-activation of the traumatic stress response as well as attention to dissociative responses can yield benefits in self-awareness for these clients (Ogden, 2020)..

P*hilosophy and principles of treatment* are recognized and adhered to. These include but are not limited to many of the issues discussed above and especially respect

for the individual and their right to self-determination; belief in natural healing potential and resilience; a mindset of strength-based empowerment including client preference about treatment strategies and their responsibility for their own motivation and healing; incorporation of ***p****rinciples of trauma-informed care*; the use of evidence-based and supported-treatments wherever possible in the treatment; specialized knowledge and training of the therapist; professional self-presentation and demeanor on the part of the therapist; and recognition of the impact of trauma on the treating therapist and others. ***P****rofessional standards and ethics* are also treatment foundations. Therapists must practice within the strictures of their profession and be especially mindful of the ethics dictum, "First, do no harm." As pertains to traumatized clients, this can be re-phrased as "First, do no *more* harm" (Courtois, 2012). Therapists are not expected to conduct treatments that are free of errors, but they are expected to practice personal mindfulness and self-management and to engage in ethical behavior.

Relational Treatment

The therapeutic ***r****elationship* is a core element of successful treatment for complex interpersonal trauma. A ***r****esponsive* and ***r****esponsible* therapist extends ***r****espect* to the client, a position that counters previous disregard and disrespect. The treatment goal is the *resolution of the trauma* and its most egregious effects wherever possible and the client's *recovery,* including the development of a life worth living that is self-determined and largely devoid of ongoing trauma symptoms. The therapist takes a stance of ***r****esonance with and* ***r****eflection of the client* to engage them in self-exploration, leading to ***r****estoration of self* and increased capacity for ***r****elational engagement and intimacy*. Therapists work according to a learning and change model and expect ***r****elapses and* ***r****uptures*, not perfection, in the healing process, something they teach their clients.

Relational ruptures should be expected, and when they occur, the therapist identifies them and seeks to engage in their repair. as these are often very significant events in a client's relational development. Boundary management is especially important as these clients' boundaries have been violated, often repeatedly, and many have been conditioned into dual and transactional relationships, something they might project into the therapy and onto the therapist. Awareness of ***R****isk* and knowledge about ***r****isk-management* in this population are also important issues for which therapists must carefully prepared (Courtois et al., 2020).

Integrated Treatment

The unique ***i****dentity* of the client, including issues of ***i****ntersectionality and personal contextual factors* are ascertained to deepen understanding of the client and their exposure/experience and subjective response. This assists in providing an ***i****ndividualized and* ***i****ntegrated* treatment. As noted, this customization may include the use of many

different strategies, paces, and chronologies, all adapted to the client. The ***i**ntensity of the treatment* is titrated throughout to keep the client in a window of tolerance and not in ongoing conditions of hyper or hypoarousal. The client's ***i**dentity development (and **i**ntegration* in cases where it is highly fragmented and dissociated) is a major goal.

The ***i**mpact of this work on the therapist* is specifically discussed in the trauma-informed care literature and approach. When unacknowledged and unaddressed, vicarious trauma and secondary traumatic stress can put both therapist and client at risk. To both tolerate the strain that accompanies this work and to sustain themselves, therapists (along with their program administrators, supervisors, and colleagues) need to monitor their own emotional and physical health, their life quality and satisfaction, and receive ongoing support through consultation, supervision, continuing education and other methods. This can also be facilitated by all working from the same overarching trauma-informed and responsive framework and philosophy.

Safety and Security

This treatment begins with a focus on personal ***s**afety*, a focus that extends throughout the treatment. Recovery is difficult if not impossible without personal, relational, and environmental safety. At times, absolute safety is impossible to achieve. When that is the case, ***s**kills and **s**trategies for **s**afety* are taught and reinforced using a collaboratively devised ***s**afety plan*. Not uncommonly, complex trauma clients lead chaotic and drama-filled lives. Where these come to light, the therapist must seek to teach life ***s**kills for **s**tabilization and self-regulation*. Education occurs across the entire course of treatment.

Relationally, the therapist strives to provide a "***s**ecure base*" and a "***s**afe haven*" to ***s**upport* the client in self-exploration and trauma processing. As noted above, the relational context can be highly activating for the interpersonally traumatized client, many of whom initially respond using the "tried and true" methods associated with their primary attachment style, i.e., their coping responses and adaptations developed as defense and self-protection. The therapist must be prepared to bring these ***s**tyles of attachment and their associated **s**trategies to the client's attention* as they introduce them to other methods. The therapist also teaches ***s**kills for emotional and other **s**elf-regulation* starting by co-regulating with the client as a model for an increased capacity for self-regulation. The treatment and especially the impact of a secure relationship assists the client in developing a more ***s**ecure **s**tyle* usually labeled as "earned secure".

The treatment is holistic in its orientation and scope. Therefore, attention to ***s**omatic* issues, presentations, and distress are warranted. ***S**omatic approaches* may be used in conjunction with other strategies to assist with affective identification and self-regulation. Personal mindfulness and strategies such as breathing, yoga, directed artwork

or writing, or personal journaling might be used to help the client calm their bodies and clear their minds.

The therapist places emphasis on ***s****elf-care* and components of a healthy lifestyle, something that might be quite new to the client since illness (some of it psychosomatic) and inattention to personal well-being (as conclusively identified in the ACES studies), personal risk-taking, disengagement from self, and self-neglect are so prominent in this population.

For the therapist, ongoing **s**ources of ***s****upport including* ***s****upervision and consultation* (whether individual or in a group) are highly recommended. Such activities offer outside support and perspective that help therapists in managing their own reactions/countertransference /vicarious trauma responses and in directing the treatment. They can be invaluable when the therapist is amid personal life crises or when crises develop in the context of the treatment.

Multi-Modal Treatment

This treatment can incorporate and integrate strategies and modalities from across all therapeutic orientations. This treatment is increasingly conceptualized as **m**ulti-**m**odal and **m**ulti-dimensional in application and as encompassing **m**ulti-component models, all selected and applied according to the therapist's training and experience and the client's needs. The intensity of the treatment is deliberately **m**odulated throughout to accommodate the client's status, capacities, and resources and to remain in the window of tolerance. Moreover, throughout the treatment, the client's ***m****otivation* is assessed and enhanced as needed. Clients are encouraged to own and lean-into their recovery efforts and are reinforced for their motivation, hard work, and treatment gains. The therapist is free to **m**odify the treatment as it progresses according to client feedback, repeat assessments, and clinical observations and judgment.

Memory processing through exposure rather than avoidance is the recommended treatment for the deconditioning and resolution of the trauma response. It is not a process that can be applied to all clients, as some are unable to tolerate it and some choose not to address the trauma directly.